Patient_____ Birthdate _____
Address_____Phone #_____

1 MONTH CHECK UP

FEEDING ROUTINE (circle): Breast Feeding Bottle Feeding Both

Breastfeeding: every___hrs for ___minutes ~~ Is your child taking Trivisol vitamins? ___

Formula type_____Ounces per feeding?_____ Every how many hours?_____

# of Bowel Movements Daily _____ # of "Wet" diapers Daily _____

How many times does baby wake at night? _____

Do you have any feeding concerns?_____

Have there been any major changes in your family recently?

_____

Any questions or concerns for the doctor?

_____

_____

_____

Developmental Milestones: Circle all that apply

Looks at people
Smile responsively
Responds to sound
Vocalizes sounds other than crying
Lift head up while on stomach
Turns head side to side

Exam Date:_____
Weight:_____ Height:_____ Temp:_____ Head Circumference:_____